Name: ____________________ Date of Birth:_______________ Date:_____________

Person Filling out this form:_____________________ Relationship:________________

*Check any of these areas that **you** are **currently** having issues with:*

- ☐ Age-related Macular Degen.
- ☐ Blurred vision
- ☐ Bothersome night glare
- ☐ Burning
- ☐ Cataract
- ☐ Pink Eye (Conjunctivitis)
- Diabetes
- ☐ Discharge from the eye
- ☐ Double Vision
- ☐ Dry Eye
- ☐ Eye pain
- ☐ Eyestrain
- ☐ Glaucoma
- ☐ Headache
- ☐ Itching
- ☐ Poor night vision
- ☐ Floaters (PVD)
- ☐ Redness
- ☐ Retina issues
- ☐ Severe sensitivity to light
- ☐ Excessive Tearing
- ☐ Total Loss of Vision

*Check any of these systems for which **you** have health issues:*

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ear, Nose or Throat
- ☐ Nervous system
- ☐ Psychiatric
- ☐ Heart and circulatory system
- ☐ Respiratory system
- ☐ Gastro Intestinal system
- ☐ Urinary or Genital systems
- ☐ Muscles or bones
- ☐ Skin
- ☐ Endocrine system
- ☐ Blood or Lymphatic systems
- ☐ Immune system or allergies

*Check any of these eye related issues for which **you** have a history:*

- ☐ High eye pressure
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age-related Macular Degen.
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal hole or detachment
- ☐ Retinal degeneration
- ☐ Keratoconus
- ☐ Traumatic Injury
- ☐ Dry Eye
- ☐ Nystagmus
- ☐ Other: ___________________

*Check all that apply for **family** members (Father, Mother, Sister, Brother, Son or Daughter)*

- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Other: ___________________

*Check all that apply for **family** members (Father, Mother, Sister, Brother, Son or Daughter)*

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ High Blood pressure
- ☐ Other: ___________________

Yes	No	***Do You:***
☐	☐	Use Alcohol
☐	☐	Use Tobacco

Primary Doctor:_______________________________________

Signature:______________________________________ Date: _______________